father of Kenneth L. Saunders, Jr. The efforts of Dr. Saunders in the community and the church have benefited many citizens throughout his career.

I ask my colleagues in the United States House of Representatives to join me in recognizing the outstanding accomplishments of Dr. Kenneth L. Saunders, Sr., an exemplary citizen that I am proud to represent here in Congress.

AN EXCERPT FROM DR. ARNOLD S. RELMAN'S NEW REPUBLIC ARTICLE: ''THE HEALTH OF NATIONS''

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 10, 2005

Mr. STARK. Mr. Speaker, I rise today to recognize an excellent article recently published in the New Republic. It has been apparent for years that free market solutions will do nothing to ameliorate the healthcare crisis in our nation. This article, authored by Arnold S. Relman, M.D., the former editor of the New England Journal of Medicine, shows us exactly why market forces hinder, not help our attempts to reform the system.

In his article, Dr. Relman explains how free market approaches—focused on consumer driven health care and individually purchased high deductible health plans—will only exacerbate the problem of the uninsured. The only thing that is empowered by these solutions is blatant discrimination against the sick and poor who will not have affordable access to care. We already have 45 million uninsured in this country, and according to Dr. Relman that number will only continue to grow if we continue down this dangerous path.

Dr. Relman proposes a solution that isn't politically popular but would fix the myriad problems in our current system. It starts with a ''tax-supported national budget for the delivery of a defined and comprehensive set of essential services to all citizens at a price we can afford.'' This universal system would rely on networks of not-for-profit providers supplying all the care covered under the national plan. A new federal agency would administer the plan, generating huge economies of scale and reducing spending by billions. This is the only real solution to our current crisis, and I commend Dr. Relman for taking a tough stand on this difficult issue.

It is with pleasure that I submit the attached excerpts from the article, ''The Health of Nations,'' for inclusion in the CONGRESSIONAL RECORD. The article originally appeared in the March 7, 2005 edition of the New Republic.

[From the New Republic, March 7, 2005]

EXCERPTS FROM: THE HEALTH OF NATIONS

(By Arnold S. Relman)

In this past election season, our dysfunctional and extravagantly expensive health care system was pushed off the front pages by concerns about the candidates, the fight against terrorism, and the war in Iraq. And yet the health system's problems will not go away; sooner or later we will have to solve them or face disastrous consequences. Over the past four decades (starting just before the arrival of Medicare and Medicaid), both the system itself and ideas about how it should be reformed have changed a lot, but an equitable, efficient, and affordable arrangement still eludes us.

During the past four decades our health policies have failed to meet national needs because they have been heavily influenced by the delusion that medical care is essentially a business. This delusion stubbornly persists, and current proposals for a more ''consumer-driven'' health system are likely to make our predicament even worse. I wish to examine these proposals and to explain why I think they are fundamentally flawed. A different kind of approach could solve our problems, but it would mean a major reform of the entire system, not only the way it is financed and insured, but also how physicians are organized in practice and how they are paid. Since such a reform would threaten the financial interests of investors, insurers, and many vendors and providers of health services, the short-term political prospects for such reform are not very good. But I am convinced that a complete overhaul is inevitable, because in the long run nothing else is likely to work . . .

. . . In 1963, a seminal analysis of the medical care system as a market was published in the American Economic Review by the distinguished economist Kenneth J. Arrow. He argued that the medical care system was set apart from other markets by several special characteristics, including these: a demand for service that was irregular and unpredictable, and was often associated with what he called an ''assault on personal integrity'' (because it tended to arise from serious illness or injury); a supply of services that did not simply respond to the desires of buyers, but was mainly shaped by the professional judgment of physicians about the medical needs of patients (Arrow pointed out that doctors differ from vendors of most other services because they are expected to place a primary concern for the patient's welfare above considerations of profit); a limitation on the entry of providers into the market, resulting from the high costs, the restrictions, and the exacting standards of medical education and professional licensure; a relative insensitivity to prices; and a near absence of price competition.

But perhaps the most important of Arrow's insights was the recognition of what he called the ''uncertainty'' inherent in medical services. By this he meant the great asymmetry of information between provider and buyer concerning the need for, and the probable consequences of, a medical service or a course of medical action. Since patients usually know little about the technical aspects of medicine and are often sick and frightened, they cannot independently choose their own medical services the way that consumers choose most services in the usual market. As a result, patients must trust physicians to choose what services they need, not just to provide the services. To protect the interests of patients in such circumstances, Arrow contended, society has had to rely on non-market mechanisms (such as professional educational requirements and state licensure) rather than on the discipline of the market and the choices of informed buyers.

Of course, another conclusion could have been drawn from Arrow's analysis (though he apparently did not draw it). It is that medical care is not really a ''market'' at all in the classical economic sense, and therefore that the basic theories of economics are not relevant to the discussion of the first principles of health care. But our society assumes that market economics applies to virtually all human activity involving the exchange of goods or services for money, and this dogma is rarely questioned. Most economists would acknowledge that medical care is an imperfect or idiosyncratic market, but still they believe that it is a market, and that it should therefore obey economic predictions . . .

. . . In 1980, in The New England Journal of Medicine, I described this changing face of American health care as the ''new medicalindustrial complex.'' The term was derived, of course, from the language that President Eisenhower had used (''military-industrial complex'') when warning the nation, as he was retiring, about the growing influence of arms manufacturers over American political and economic policies. Referring to Arrow's analysis, I suggested that market-driven health care would simply add to the explosion of medical expenditures and the growing problems of inequity and variable quality. I was also worried that this uncontrolled industrial transformation would undermine the professional values of physicians, which are surely an essential ingredient of any decent medical care system. Financial incentives were replacing the service ethic of doctors and hospitals, as the providers of care began to compete for market share and larger income. Yet competition on the basis of the price and quality of services—an essential characteristic of most free markets—was little in evidence, demonstrating again the truth of Arrow's argument that the medical care market was different . . .

. . . In an increasingly profit-driven and entrepreneurial medical market, piecework payment for specialized outpatient services stimulated an even greater fragmentation of medical care and a greater use of individually billable items of outpatient technological service. Less attention was given to the continuity and the integration of care, and to preventive medicine. Decreased payments to primary-care physicians and increased pressure on them to see more patients reduced the time that they spent with each patient. As a consequence of all these developments, the quality of primary care suffered, and the difference between the quality of average medical care and the best medical care widened, even as per capita expenditures rose and the number of uninsured and underinsured patients increased. This quality ''gap'' was the subject of a major report in 2001 from the Institute of Medicine of the National Academy of Sciences, which described the many deficiencies in the way patients were being treated and suggested how their medical care could be improved. Unfortunately, the experts preparing the report were not asked to consider how the system itself might be restructured to facilitate the needed improvements.

And so we now live with a seriously defective medical care system, based more heavily on market incentives than the health care regime of any other country in the world. The commercial tone is set by investor-owned insurance companies (the major share of the private insurance market), investor-owned hospitals (about 15 percent of all community hospitals), and investor-owned ambulatory-care facilities and nursing homes (the great majority of both these markets). The behavior of many of the so-called ''not-for-profit'' health care facilities is not much different from that of their investor-owned competitors, because they have to survive in the same unforgiving marketplace, which is indifferent to the social values that originally motivated most health care institutions. As for American physicians, their attitude toward their profession has also been changed by the new medical marketplace. To a degree greater than anywhere else in the world, our doctors think of themselves as competitive business people. As such, they own or invest in diagnostic and therapeutic facilities (including specialty hospitals), they form investor-owned medical

groups, and they advertise their services to the public . . .

. . . Our failure to address the glaring deficiencies and inequities in our health care system is nothing to be proud of. A growing number of people are losing their private health insurance. There are now more than 45 million Americans without coverage. Much of this is due to the loss of good jobs, but high costs are also a significant factor. The financial burdens of those who are insured increase steadily, as hard-pressed employers reduce covered benefits and increase the fraction of insurance costs being shifted to beneficiaries. Rising health costs are threatening the financial stability and competitiveness of many American businesses, and are discouraging the hiring of new full-time workers. The government is also shifting insurance costs to Medicare beneficiaries, as exemplified by the recent large increase in the premium charged for coverage of outpatient medical services and physicians' care (''Part B'').

What really astonishes me is that so many conservative business and health policy experts continue to hold an unshakable faith in a market solution for our system's major problems. They believe that market forces have not been allowed to contain costs or to improve access and quality because of government regulation, and because of badly designed insurance that prevents consumers from playing an appropriate role. They think that the consumers of medical care in both public and private insurance systems have not had enough influence on the supply of services and have not been sufficiently involved in price negotiations with providers. These days the ''free market'' is held to be the solution to most social and economic problems, and it is commonly believed that in health care the most important missing ingredient of a free market is the traditional consumer who has the incentive and the ability to bargain for the desired price and quality of services. So it shouldn't be surprising that the idea for improving our health care system that is currently most popular is so called ''consumer-driven health care,'' or CDHC.

The term ''consumer-driven health care'' is used to mean a market for medical care in which patients, as the ''consumers'' of medical services, would have a lot more responsibility for choosing those services and would share more of the costs. In the most fully developed proposals, providers of medical care (physicians, hospitals, clinics, and so on) would compete for patients on the basis of quality, price, and convenience—not simply for market share, as they do now. Patients, like consumers in any service market, would have access to all the information they need to make their own health care choices. They would choose and own their insurance plans. They would select not only their health care providers, but also the particular medical services they want. Since they would share more of the costs, they would have an incentive to make prudent choices and to demand higher quality. The net result, it is claimed, would be a better, less expensive health care system . . .

. . . The assumption of the CDHC system is that such a plan would moderate health care inflation by encouraging patients to become more prudent consumers of elective and non-catastrophic health services, because they would be spending money they otherwise could invest in their savings account. It is also assumed that in competing for business, the providers of medical care would try to make their services more attractive to patients by improving quality and convenience, as well as by moderating their prices . . .

. . . There are compelling reasons, I think, to predict that they will not. For a start, high-deductible insurance is not likely to produce reductions in expenditures, except among low- and modest income families, who would feel financial pressure to cut their doctor visits and their use of other medical services. There is good experimental evidence that high deductibles have such selective effects, which expose the most vulnerable patients to greater health risks. Higher earning beneficiaries would not feel such pressure and would continue to use all medical services freely. Whatever reductions in total expenditures might occur would be achieved largely through reducing services to those with lower earnings. Adjusting the size of the deductible in approved plans to the income of the beneficiaries might ameliorate that injustice, but it would add to administrative costs and would be virtually impossible to do properly—given the difficulties in making fair assessments of financial need.

If people were allowed to select whatever insurance plan they wanted, the inequity would probably increase in another way. Healthy, young families would choose the least expensive plans with the highest allowable deductible, and those with health problems would be forced to choose plans with the lowest allowable deductibles but higher premiums. The premiums or the required copayments of the latter plans would spiral upward because of the greater use of services by sicker beneficiaries, so it would become even harder for those with the greatest need for insurance to afford coverage. In this way, one of the most important values of insurance—the sharing of risks over a broad population base—would be lost. Adjusting the contribution of employer or government to the health status of the beneficiaries has been suggested as a means of avoiding this problem, but the relatively primitive state of the art of risk adjustment and the difficulty in applying it to families make this solution unlikely. It also would add greatly to administrative costs . . .

. . . The CDHC plans that are now being advocated by believers in the magic of markets shift to patients not only a large part of the responsibility for being their own doctors, but also the burden of paying more of the cost—and that burden would be heaviest on the poorest and sickest of our citizens. This is surely a denial of the ethical principle underlying universal coverage and the sharing of costs. But the major payers, government and employers, are no longer willing or able to shoulder health care's rising costs, and so they are promoting CDHC. They may justify their views by arguing that it makes sense to shift more of the costs to patients because patients are in the best position to put the brakes on health cost inflation. This might be a reasonable argument if medical care were like other services in other markets—but it is not.

For all these reasons, then, ''consumer-driven'' plans are unrealistic and unfair, and they are not likely to be politically viable in the long run. There is some understandable support for the idea that individuals should be more responsible for the cost of elective or optional medical services, but most people believe that the availability of needed services should not depend on ability to pay. We are a wealthy society, and decency requires that we make equitable arrangements to ensure at least minimally adequate health care for all—a goal that is beyond the scope of market forces. . . .

. . . When that time comes, we should be prepared to replace a failed market-based system with a better one that can deliver the health care we need. What kind of system might that be? The question cannot be confidently answered in any detail before the market-based system has run its course, and before there has been some preliminary experience with non-market-based models—perhaps at first in a few states. Still, a few general principles and objectives can be proposed now, based on what we have learned from our experience during the past four decades and on what we know about the essential nature of medical care.

First, since we cannot rely on the free play of markets to control costs or guarantee universal coverage, we should establish a tax-supported national budget for the delivery of a defined and comprehensive set of essential services to all citizens at a price we can afford. Employers should pay an appropriate part of the tax for their employees. These services should include both acute and long-term care, and they should be exclusively reimbursed through a single-payer national insurance plan, with other elective and non-essential services paid out of pocket or through privately purchased insurance. No services covered by the national plan should also be covered by private insurance plans, but the latter could insure services, such as ''aesthetic'' plastic surgery and private hospital rooms, that would not be covered by the national plan. There should be no billing by providers and no piecework payment in the single-payer plan, thus eliminating the huge business costs and the colossal hassle of the present billing and payment systems in multiple public and private insurance plans.

Second, not-for-profit, prepaid multi-specialty groups of physicians should provide all necessary medical care on the approved list of insured services. The physicians in the groups should be paid salaries from a pool of money that would be a defined percentage of the total patient income received by the group from the central payer. The groups should be privately managed but publicly accountable for the quality of their services, and they should be expected to use standardized information technology that could be integrated into a national data system. They should be indemnified against losses due to adverse selection or other costs beyond their control, assisted with start-up and technology expenses, and exempted from anti-trust restrictions. They should compete for patients on the basis of the quality of their services. All groups should be open to all citizens, although the number of members for a given-sized group should be regulated to ensure an appropriate ratio of doctors to patients.

Third, patients should be free to choose their own physician group and to switch membership at specified intervals, but everyone must be included in the national plan and belong to a group—including politicians. (Lawmakers are unlikely to neglect the needs of a health care system that provides care for themselves and their families.)

Physicians should be free to join any group that wanted them and to change their affiliation, but they should not provide services outside the national system that are covered by the latter.

Fourth, all health care facilities (whether privately or publicly owned) that provide services covered by the central insurance plan should be not-for-profit, and should compete on the basis of national quality standards for patients referred by the physicians in the medical practice groups. Facilities should be paid, and monitored for their performance, by the central plan. They should have no financial alliances with the physicians or the management of the medical groups. Teaching facilities should be separately funded by the national plan and be paid for their extra costs, including education. Budgets in all facilities should include salaries for full- and part-time clinicians providing essential services.

Fifth, the health care system should be overseen by a National Health Care Agency,

which should be a public-private hybrid resembling the Federal Reserve System. It should be independently responsible for managing its budget and establishing administrative policy, but should report to a congressional oversight committee and to the public. It is essential that the plan be sufficiently independent of congressional and administration management to be protected from political manipulation and annual budgetary struggles. . .

. . . Our present medical care system lacks the structure and incentives to improve the quality of care. A not-for-profit system of salaried physicians, who work together in groups that have no financial incentive to do more or less than is medically appropriate, who compete with other medical groups only on the basis of quality and their attractiveness to patients, and whose results are publicly accountable, could be expected to deliver the kind of health care we need. The quality of care would also be improved by a system of competing not-for-profit facilities that are held to national standards.

As for access and equity, the plan outlined here would guarantee universal coverage for all essential services and would allow employers and individuals to share in the costs through an earmarked and graduated tax. The government would be expected to pay the costs of today's uninsured, as well as the contributions it now makes to government insurance programs. Given the large savings expected in this system, the change in net costs to government should be minimal. . .

. . . A real solution to our crisis will not be found until the public, the medical profession, and the government reject the prevailing delusion that health care is best left to market forces. Kenneth Arrow had it right in 1963 when he said that we need to depend on ''non-market'' mechanisms to make our health care system work properly. Once it is acknowledged that the market is inherently unable to deliver the kind of health care system we need, we can begin to develop the ''nonmarket'' arrangements for the system we want. This time the medical profession and the public it is supposed to serve will have to be involved in the effort. It will be difficult, but it will not be impossible.

CHINA'S ANTI–SECESSION LAW

HON. MAURICE D. HINCHEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 10, 2005

Mr. HINCHEY. Mr. Speaker, I rise today to bring to my colleagues attention an anti-secession bill that is currently under consideration in The People's Republic of China's National People's Congress Standing Committee. Although the language of the draft of this law has not been made public, many Taiwanese are troubled. They are concerned that if such legislation is passed it may lead to future military action against them if Taipei does not succumb to Beijing's One China principle. This proposal should concern the United States because of our commitment to help preserve a democratic Taiwan.

However, Beijing should be commended for its recent conciliatory gestures that appear aimed at lowering tensions across the Taiwan Strait. These include the first non-stop, cross-strait charter flights between the mainland and Taiwan for the February Lunar New Year holiday and the dispatch of two senior Chinese officials to the funeral of Koo Chen-fu who headed Taiwan's Straits Exchange Foundation. Yet the impending law could prove counterproductive to these actions in several ways.

The proposed law could result in China taking military action against Taiwan if it appears to Beijing that Taiwan is moving toward independence. Most Taiwanese would like to peacefully co-exist with the mainland, if creative ways to do so can be negotiated between Beijing and Taipei.

The status of hundreds of thousands of Taiwanese living in China could also become uncertain as a result of this legislation. Some have questioned whether this means that statements interpreted as supporting Taiwan could be the legal basis for charges of treason or other criminal actions—a scenario causing deep concern in the Taiwanese business community on the mainland.

Furthermore, the law has received a negative reaction from the citizens of Taiwan and could lead to increasing support for the very independence moves it seeks to deter. This legislation will not encourage negotiations that are needed to attain a peaceful resolution to tensions in the Taiwan Strait.

President Bush clearly stated that the basic tenets of his foreign policy will be the expansion of democracy and freedom across the globe. It is my hope that the Bush Administration will encourage China not to pass the proposed antisecession law.

A PROCLAMATION HONORING MR. CLIFF McKARNS ON HIS 85TH BIRTHDAY

HON. ROBERT W. NEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 10, 2005

Mr. NEY Mr. Speaker:

Whereas, Cliff McKarns was born on February 19, 1920, and is celebrating his 85th birthday; and

Whereas, Cliff McKarns, a World War II Veteran who is to be commended for his great service to our nation; and

Whereas, Cliff McKarns is a retired farmer and employee of Summitville Tile in Summitville, Ohio; and

Whereas, Cliff McKarns is loved and appreciated by all his family members.

Therefore, I join with the family of Mr. Cliff McKarns and the residents of the entire 18th Congressional District of Ohio in wishing Mr. Cliff McKarns a very happy 85th birthday.

HONORING THE CONTRIBUTIONS OF BEXAR COUNTY COMMISSIONER PAUL ELIZONDO

HON. HENRY CUELLAR

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 10, 2005

Mr. CUELLAR. Mr. Speaker, I rise to recognize Bexar County Commissioner Paul Elizondo for a lifetime of distinguished public service.

Paul Elizondo began public life as a music teacher in the Edgewood and San Antonio public school districts. He was a member of a wide variety of professional organizations, including the National Education Association, the Texas Classroom Teachers Association, and the Music Educators National Conference.

He was first elected to the State House of Representatives in 1978, and served for four years, working on the Public Education, State Affairs, and Constitutional Amendments committees. In 1983, he made the transition to county service. He was elected Commissioner for Precinct 2, and has been serving San Antonio as a Bexar County Commissioner for over 20 years.

He has been involved in a wide variety of community organizations, including the Center for Health Care Services, the Metropolitan Planning Organization, the Private Industry Council, and the National Council of Community Mental Health centers. An energetic public servant, a veteran of the United States Marine Corps, and a beloved teacher he is an inspiration to the community.

Mr. Speaker, Bexar County Commissioner Paul Elizondo is a credit to his community and a tremendous resource to his county.

H. RES. 16, NATIONAL MANUFACTURING WEEK

HON. RON KIND

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 10, 2005

Mr. KIND. Mr. Speaker, I rise to speak favorably on House Resolution 16, supporting the goals of National Manufacturing Week, congratulating manufacturers and their employees for their contributions to growth and innovation, and recognizing the challenges facing the manufacturing sector.

The American manufacturing industry has been a key to our economic success in the past, and will continue to be a key to our economic success in the future. As a member of the Congressional Manufacturing Task Force, I have focused on how the federal government can most effectively help small and medium sized manufacturers compete and grow in western Wisconsin and throughout the country. Through good investments and smart practices, the federal government can better assist American companies and help our nation keep its economic edge.

We need to invest in proven programs that help small and medium sized businesses, such as the Manufacturing Extension Partnership (MEP). The MEP provides our manufacturers with the tools to compete in a competitive marketplace. It increases our country's manufacturing productivity and competitiveness, resulting in expanded economic activity and an enhanced tax base. It aids in the creation and retention of well-paying manufacturing jobs for American workers, and it is vital to our nation's small manufacturers. That is why I have supported level funding of $109 million for the MEP in FY 2006.

Mr. Speaker, I fully support House Resolution 16, supporting the goals of National Manufacturing Week, and I congratulate American manufacturers for their contributions to our economic success.